United States Senate
Republican Policy Committee
Jon Kyl, Chairman
Lawrence Willcox, Staff Director
347 Russell Senate Office Building
Washington, DC 20510
202-224-2946
http://rpc.senate.gov

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RPC Backgrounder:

Medicare Payment Policy and the Budget

Introduction

The President's FY 2006 Budget proposal, submitted to Congress yesterday, recognizes the need to stabilize the Medicare program in preparation for the historic prescription drug benefit that will soon become available to some 40 million elderly and disabled individuals. This new benefit and other entitlement reforms were established by the Medicare Prescription Drug, Improvement, and Modernization Act, enacted in December of 2003 [P.L. 108-173].

Specifically, the budget blueprint does not include the recommendations recently made by the Medicare Payment Advisory Commission (MedPAC) regarding hospital and physician payments. MedPAC, a group of health experts that annually makes Medicare policy recommendations for Congress, recently proposed a reduction in FY 2006 hospital reimbursements from the amount current law would provide. At the same time, MedPAC proposed an increase in 2006 payments to physicians. Because MedPAC is an advisory arm of Congress, lawmakers will want to examine these recommendations.

This background paper reviews Medicare's payments to hospitals and physicians. It examines the interdependence of beneficiaries, providers, and the federal government, and the impact Congress's decisions will have on medical care offered to Medicare beneficiaries.

Hospitals in Profile

The breadth of Medicare's coverage is significant. Not only does it serve many Americans, but in a typical year, about one in five beneficiaries – or nearly 8 million patients last year – must avail themselves of its most critical services when they become inpatients in one of the country's 4,800 acute-care hospitals.[1] Medicare payments represent nearly 40 percent of an average hospital's total income (having grown from 34.6 percent in 1980 and 38.5 percent in 2003).[2]

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[1]Medicare Payment Advisory Commission, "MedPAC Brief: Hospital inpatient services payment system," July 2004.

[2] MedPAC, "Hospital Inpatient Brief," and The Lewin Group, 2003.

Congress created Medicare to cover the inpatient hospital needs of the elderly, initially providing that hospitals be reimbursed retroactively on the basis on their costs, i.e., the cost of treating a specific Medicare patient. Many years later, due to concerns over rising inpatient hospital costs and increasing Medicare enrollment, Congress instructed the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services) to develop a new payment system that would reimburse hospitals at a predetermined rate for each condition, disease, or treatment.

The new payment regime, the Prospective Payment System (PPS), implemented in 1984, established a standardized payment amount that is based on the average cost of care for the treatment of a typical Medicare patient. The standardized payment to hospitals is adjusted to reflect: 1) relative severity of a patient's medical condition; 2) resources related to treatment; and 3) differences in the type and geographic location of the hospital providing the care. Additionally, the standardized payment amount is increased each year to address inflation using a measuring unit called the "hospital market basket" (although in some years, Congress has elected not to provide the full inflationary increase). This hospital market basket is akin to the "market basket" used to compute the changes in the Consumer Price Index. However, instead of measuring an increase in what consumers typically buy for household use, e.g., food, clothing, and personal-care products, the hospital market basket measures annual expenses related to what hospitals must buy, e.g., beds, blood products, labor, and drugs, in order to furnish patient care.[3]

When a hospital files a claim on behalf of an inpatient who is a Medicare beneficiary, the standardized payment amount is adjusted by a diagnostic related group (DRG) factor. These factors are designed to ensure that less complex medical cases receive lower payments and more complex cases receive higher payments. There are approximately 500 different DRG classifications, which are re-weighted each year. Moreover, other payment adjustments are applied to account for medical education, indigent care, excessive medical complexity, and employment of new technologies.[4]

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[3]The market basket comprises almost 90,000 different goods and services to determine hospital operating expenses, such as the cost of labor, technology, blood products, and pharmaceutical expenses. The Centers for Medicare and Medicaid Services (CMS) publishes the rate of increase each year as part of its rulemaking obligations. However, Congress has authority to decrease the update amount each year.

[4]Centers for Medicare and Medicaid Services (CMS), "Acute Inpatient Prospective Payment System," (www.cms.hhs.gov/providers/hipps/ippsover.asp). Various adjustments include: 1) Indirect Medical Education (IME) payments to help pay for the higher cost of care associated with medical resident training programs; 2) Medicare Disproportionate Share Hospital (DSH) payments to help compensate for revenue losses associated with the treatment of low-income patients; and 3) outlier payments to help account for unusually expensive cases.

Unintended Consequences of the Balanced Budget Act (BBA) of 1997 on Hospitals

During the mid-1990s, Congress and the White House faced a large and seemingly intractable federal budget deficit.[5] The scenario deteriorated when the Medicare Board of Trustees, a group of government and private-sector healthcare actuaries and policymakers, projected that the Hospital Insurance (HI) Trust Fund would be bankrupt and unable to pay hospital inpatient benefits by 2002.

Congress responded by passing the Balanced Budget Act of 1997 (BBA), which contained a comprehensive set of Medicare payment reductions aimed at most healthcare providers. For hospitals, the BBA specifically froze the market basket update for FY 1998. And, the updates for the remaining four years of the BBA were reduced by varying percentage points. It also cut Medicare payments for capital, bad debt (unpaid Medicare co-pays and deductibles), indigent care (specifically, disproportionate share payments which cover Medicaid and Supplemental Security Income eligible persons), and medical education assistance (specifically, indirect medical education). Additional payment reductions targeted outpatient and post-acute care services, such as home health, skilled nursing, and rehabilitative care – the effect of which was a reduction in hospital reimbursement across the board.[6]

The BBA received wide bipartisan support, but it was not clear to Congress at the time just how much the payment reductions would affect hospitals – and, more importantly, hinder access to critical medical care for Medicare beneficiaries. Only later did the full budgetary impact become clear: during a Senate Finance Committee hearing in 1999, Paul N. Van de Water, Assistant Director for Budget Analysis at CBO, testified that the original Medicare savings for FY 1998-2002 had been projected to be $112 billion. However, when CBO revised those estimates, it found that the BBA payment provisions actually amounted to $197 billion in net Medicare payment reductions over the same period.[7] What this means is that Congress passed a bill extracting significantly more in payment reductions than it had originally intended.

In terms of anecdotal evidence, the impact on access to care was telling. Many hospitals were forced to close or curtail certain services, as well as delay investments in facility infrastructure. For instance, the Phoenix Baptist Hospital and Medical Center in Phoenix, Arizona, was forced to sell its 128-bed skilled nursing facility and decrease the number of

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[5]Office of Management and Budget, The Budget for FY 2005, Historical Tables.

[6]CBO Testimony, Statement of Paul N. Van de Water, Assistant Director for Budget Analysis, on the "Impact of the Balanced Budget Act on the Medicare-Fee-For-Service Program," before the Senate Committee on Finance, June 10, 1999.

[7]CBO Testimony, "Impact of the BBA," June 10, 1999.

available home health services because of the impact of the BBA on its income.[8] The impact of hospital closures or cutbacks had a domino effect on non-Medicare patients, as well. In Stuart, Florida, for example, the Martin Memorial Health System decided to close its midwife program after having provided prenatal services to area mothers for 17 years based on a projected $30 million loss in BBA-related Medicare payments over five years.[9] Throughout the country, hospitals related similar experiences.

Healing the Wounds of the 1997 Act

Over the years, Congress has revisited the 1997 law in an effort to alleviate these unintended consequences. For instance, in 1999, it passed the Balanced Budget Refinement Act, which included higher hospital outpatient payments, increased rural hospital adjustments, and enhanced medical education assistance payments. In 2000, Congress acted again by passing the Medicare and Medicaid Benefits Improvement and Protection Act, which contained an increase in the inpatient update factor, higher medical education assistance, enhanced indigent care payments, and higher Medicare bad debt payments. Collectively, these measures provided $20 billion in new hospital relief funding over a seven-year period.

Most recently, in 2003, Congress passed the Medicare reform law. In addition to an important new prescription drug benefit for beneficiaries, the law contained additional hospital provisions. First, it addressed long-standing payment inequities between rural and urban hospitals. Second, it provided a full inflationary update for FYs 2004-2007, as long as hospitals submit scientifically recognized quality reporting data for common hospital admissions. Third, the Medicare law modestly increased indirect medical education (IME) payments to help teaching hospitals continue training physicians in state-of-the-art clinical care.

Current Hospital Outlook

Despite these relief measures, new data issued by the MedPAC show that *America's hospitals are losing money when they treat Medicare patients.*[10] The data paint a grim picture of declining payment adequacy and an inability to keep pace with the rising cost of care for Medicare patients facing complex medical needs. The advisory commission judges payment adequacy by looking at an aggregate measurement known in the industry as the "Medicare margin." The margin is used to determine overall hospital financial health. A positive-number margin (see chart, below) demonstrates that Medicare hospital payments are adequate in the aggregate. However, the commission's study shows that Medicare margins are now in the

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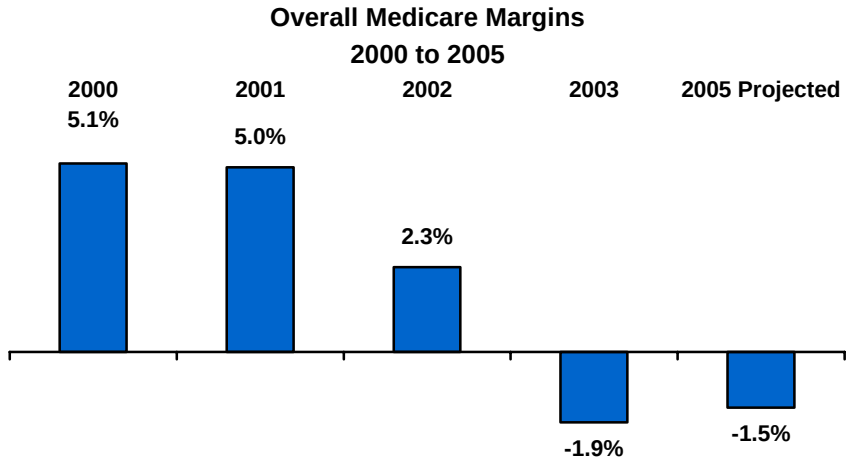
[8]The Phoenix Baptist Hospital and Medical Center is a 200+ bed facility that offers a full array of acute care services including obstetrics, cardiac care and surgery. The five-year impact of the BBA Medicare cuts, even with subsequent relief legislation, was projected to cost the hospital $11.5 million.

[9]Martin Memorial Health Systems in Stuart, Florida, is a 330+ bed facility handling a full array of community healthcare needs.

[10]MedPAC, Public Meeting Transcript, December 9, 2004.

negative. That is, in 2003, Medicare paid hospitals 98 cents for every dollar of care they provided to beneficiaries.[11] The number is projected to remain negative for 2005.



Despite this new data that show Medicare payments falling behind inflation, MedPAC recommended a *cut* in the hospital inflationary update for FY 2006 by four-tenths of a point.[12] This final recommendation came without any explanation, which is puzzling since the Commission just four weeks earlier – in a public meeting – had issued a draft recommendation that called for a full inflationary update.[13]

As earlier noted, Medicare payments represent a significant and growing portion of hospital income. If Congress were to follow MedPAC's final recommendation, it would affect quality of care: hospitals are striving to make payroll and keep up with maintenance and daily operating costs while at the same time trying to make investments in innovative care. Investment today in these latter items – including information technologies, workforce needs, new drugs, and medical devices – affects quality of care in the years to come.

[11] MedPAC.

[12] MedPAC is an independent federal body established by the BBA (P.L. 105-33). According to its mission statement, "Its 17 members offer diverse expertise in the financing and delivery of medical care." Its purpose is to provide Congress with annual Medicare payment recommendations for all participating providers, including skilled nursing facilities, home health care providers, hospitals, and physicians.

[13] MedPAC, "Public Meeting Transcript," January 12, 2005. A market basket reduction minus .4 percent is estimated to reduce Medicare spending by $6 billion over five years.

Physicians in Profile

In addition to inpatient hospital medical care, Medicare patients depend on and utilize an array of physician services. Beneficiaries rely on nearly half a million doctors who submit claims on their behalf to cover over 7,000 different Medicare-approved services.[14]

In 1992, in response to a desire to reduce and standardize reimbursements, the physician fee schedule was established by Congress.[15] The fee schedule is based on a complicated set of varying weights and measurements designed to reflect the relative value of the service performed and the varying geographic differences associated with the cost of providing such care. The relative values represent three factors: 1) physician work, such as time spent and intensity of service; 2) practice expenses, such as office rents and labor; and 3) medical liability costs.[16]

Once the relative values are calculated and adjusted geographically, Medicare then applies a conversion factor. Similar to the hospital inflationary update, the conversion factor updates physician payments annually. However, the conversion factor is based on its own separate inflationary measure, known as the Medicare Economic Index (MEI).[17] It also is subject to an arbitrary spending cap under the sustainable growth rate, as described below.

Unintended Consequences of the Balanced Budget Act (BBA) of 1997 on Physicians

Concerned that the 1992 fee schedule had failed to adequately control Medicare spending, Congress again examined physician payments five years later. As a result, the BBA established a new mechanism, known as sustainable growth rate (SGR), to cap payments when utilization increases relative to the growth of gross domestic product.[18] This means that if physicians try to make up for losses by increasing the volume of services during times of economic slowdown, physician payments are reduced.

In March 2002, the *New York Times* interviewed physicians around the country about the impact of the new SGR payment changes. Dr. Mark Krotowski, a family physician from

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[14]Medicare Payment Advisory Commission, "MedPAC Report to Congress," March 2004. This excludes nurse practitioners, physician assistants, psychologists, and other healthcare professionals.

[15]Congressional Research Service (CRS) Report for Congress, "Medicare: Payments to Physicians," January 29, 2003.

[16]Congressional Research Service (CRS) Report for Congress, "Medicare: Payments to Physicians," January 29, 2003.

[17] Committee on Ways and Means 2000 Green Book, Part B Services – Coverage and Payments.

[18]CBO Testimony, "Impact of the BBA," June 10, 1999.

Brooklyn, represented the view of many of his colleagues when he explained why he had stopped taking new Medicare patients: "My expenses go up and up and up every year. For the government to lower what it pays me when my expenses are rising – that doesn't make sense. I love my elderly patients, but they are very sick. They need a lot of attention, a lot of medications and a lot of time."[19] A Washington State physician whose practice specialized in geriatrics noted that his group would take no new Medicare patients "because the financial losses are unsustainable."[20]

Because these reactions were representative of physicians around the country – and reflect a negative impact on access to quality care – Congress has had to intervene on several occasions to help lessen the impact of cuts in physician reimbursement just as it has with hospital payments. However, each time that Congress acts, it is in the context of delaying reductions in reimbursement rather than creating a long-term solution. For instance, the Medicare reforms of 2003 eliminated scheduled cuts for physicians, but only for 2004 (4.5 percent) and 2005 (3.7 percent). Beginning next year, physicians will face a scheduled statutory cut of 5.2 percent. *This means that physician payments will be less in actual dollars than they receive today*. For example, Medicare cataract surgery payments (a common procedure for beneficiaries) are projected to decline from $684 in 2005 to $648 in 2006 due to the effects of the SGR. In 2013, these reimbursement rates are projected to drop to $469 due to the continual effects of the SGR payment policy.[21]

MedPAC recently recommended that Congress eliminate the scheduled SGR cut for next year and instead raise physician payments by 2.7 percent. According to MedPAC, a "small but consistent share" of beneficiaries continues to experience some difficulty in finding doctors who are willing to treat them due to the impact of the SGR.[22] This was the basis for its recommendation. While the proposal to eliminate the 5.2-percent cut will help maintain beneficiary access to care, MedPAC did not specify to Congress how to finance the increased payment rate. Moreover, MedPAC did not address the larger issue involving the SGR and its flaws when there is economic downturn.

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[19] *The New York Times*, "Many Doctors Shun Patients with Medicare," by Robert Pear, March 17, 2002. We note that, according to MedPAC, physicians' willingness to accept new beneficiaries is a key indicator in examining current physician supply and whether beneficiary access may be negatively impacted.

[20] *The New York Times*, "Many Doctors Shun Patients with Medicare," by Robert Pear, March 17, 2002. We note that, according to MedPAC, physicians' willingness to accept new beneficiaries is a key indicator in examining current physician supply and whether beneficiary access may be negatively impacted.

[21] CMS, "Medicare Program; Changes to Medicare Payment for Drugs and Physician Fee Schedule Payments for Calendar Year 2004; Interim Final Rule, January 7, 2004.

[22] MedPAC, "Public Meeting Transcript," January 12, 2005.

Conclusion

The Medicare population is expected to nearly double to 72 million by 2030.[23] This growth trend should not diminish the quality of care on which beneficiaries have come to rely. When senior and disabled citizens find themselves as hospital inpatients, or when they are being treated as outpatients in their doctors' offices, they rely on the federal government to assure they receive quality care. This is because the federal government serves as the agent in reimbursing providers for the health care they furnish to Medicare patients. Therefore, it is critical that Congress, when determining reimbursement payments to physicians and hospitals, keep in mind past unintended consequences as it examines MedPAC's data confirming that Medicare reimbursements are *not* keeping pace with medical inflation.

Entitlement reform is one of Congress's most important responsibilities. Whenever Congress considers changes to Medicare, it must be sure to promote fairness and predictability. It also must act in a manner that balances the need to hold Medicare costs as low as possible while preserving and ensuring quality health care for our growing population of senior citizens.

[23]Medicare Trustees Report 2004.